Health Disparities and Hispanic Elders

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Abstract

By 2050 Hispanic elders will compose a significant portion of the total population in the United States. Health care disparities among this particularly vulnerable population continue to drive the necessity to address the situation. While not only will the Hispanic elders' quality of life be enhanced, the financial burden placed on this country's health care system will also be impacted. Hispanic elders have increased uncontrolled chronic conditions such as diabetes and are also unprotected against preventable illnesses such as pneumonia; however the treatment and interventions they receive seem to lag behind. Another important psychological factor is the impact of mental health services as it relates to the Hispanic elder population. There are several factors that influence the health disparities facing Hispanic elders; in particular, their access to quality health care seems to stand in the forefront. Interventions and public health programs to address these disparities must be incorporated into health education studies.

Demographics

Hispanics of any race currently comprise 7 percent of the older population in the United States (U.S. Census Bureau, 2008) and projections indicate that by 2050 the composition will rise to 20 percent. Although the older population among all racial and ethnic groups is projected to grow significantly, the older Hispanic population is estimated to grow the fastest with a little under 3 million in 2008 to 17.5 million by 2050 (U.S. Census Bureau, 2008). The National Hispanic Council on Aging (NHCOA) (2012) reports that the while the total aging population in the United States has grown significantly throughout the last century, and that by 2030, it will compose 20% or 70 million of the population will be 65 or older. Moreover, the Hispanic population which is now the largest minority is expected to have a growth rate of 555% from 1990 to 2030, with a corresponding growth rate in their aging population (NHCOA, 2012). By 2030, it is projected that the Hispanic elderly will comprise 11.2% of the U.S. elderly population, and by 2050 it will grow to 17.5% (NHCOA, 2012).

Overview of Health Concern

The Centers for Disease Control and Prevention (CDC, 2009) describes health disparities as preventable differences in the burden of disuse, injury, violence, or in opportunities to achieve optimal health experience by socially disadvantaged racial, ethnic, and other population groups and communities. Although, the CDC acknowledges that for most Americans, life expectancy and the overall health has improved recently, not all older adults are benefitting equally due to factors such as economic status, race, and gender (CDC, 2009). The National Healthcare Disparities Report (NHDR)

commissioned by the U.S. Department of Health and Human Services, (DHHS, 2007) states that there is significant health disparities for Hispanic elders when compared to the majority, non-Hispanic white elderly population (Department of Health and Human Services [DHHS], 2007). These disparities include poorer access to health care, poorer diabetes control, and less likely to receive vaccinations for pneumonia or influenza (DHHS, 2007). Furthermore, the report asserts that elderly Hispanics face many obstacles to health care, including language and cultural barriers, which if not appropriately addressed, will continue to exacerbate the growing health disparities among the Hispanic elder population.

Hispanic elders face a number of barriers to living their golden years healthily and happily. Generally as a group, Hispanic elders have lower levels of education and a high chance of having two or more chronic diseases (NHCOA, 2012). Additionally, Hispanic elders' first language is often times Spanish and their culture and communication style may be very different than the culture of the U.S. healthcare and government systems (NHCOA, 2012). Addressing the consequences of these barriers is of upmost importance.

Because health disparities are associated with differences in race and ethnicity, it is important to understand the implications of the increase in race and ethnic diversity in the growing senior populations for future health problems, limitations and disabilities (Satariano, 2006). Race is no longer thought of as a category characterized by homogenous biologic inheritance, rather ethnicity, refers to a social group that shares a distinctive social and cultural tradition, further, the U.S. Bureau of the Census and U. S. governmental health statistics restrict the use of ethnicity to people of Hispanic ancestry

(Satariano, 2006). Within in the Hispanic community, several nationalities with varied customs and beliefs are often times grouped into the same category. For example, Mexican-origin elders may have very different views of the health care system than elders of Puerto Rican origin due to the lived experiences in their respective countries' national health care delivery systems. This one example of diversity within the Hispanic population, may explain the varying perspectives that each Hispanic individual possesses.

Health Condition

One of the leading prevention health quality indicators identified by the Agency for Healthcare Research and Quality (AHRQ) is the immunization of preventable bacterial pneumonia. Lemus et al., (2010) looked at the associations of individual and county correlates with bacterial pneumonia hospitalization rates for elders who lived in 32 Texas counties bordering Mexico. The findings reported that among the total Texas border population the rate was 500/10, 000 which represented three times the national rate for hospitalizations for bacterial pneumonia. Among the elders aged 75 and above, Latinos had the highest rates of bacterial pneumonia hospital admissions. This particular study is of significant value because the baseline bacterial pneumonia hospitalization study demonstrates how a systematic approach to estimate county rates could lead to improved outcomes through effective community interventions (Lemus et al., 2010). This would certainly lead to more effective health promotion in that it serves as an avenue for increased pneumonia immunization rates for Hispanic elders. As Ferrini and Ferrini (2008) pointed out there are significant ethnic and racial differences among those who are vaccinated against bacterial pneumonia, with less than half of Hispanics aged 65 and older being vaccinated against this preventable disease.

Ecological Factors

The National Hispanic Council on Aging (NHCOA) reported on previous literature conducted by The National Council of La Raza and the Pew Hispanic Center which found that the Hispanic elderly population is more likely to contract certain diseases, receive less preventative care, and have less access to health education or health care of all racial/ethnic groups. Furthermore, Hispanics have the lowest rates of health insurance coverage. Consequently these factors lead to disparities in health outcomes, morbidity, and eventually, mortality (NHCOA, 2007). These ecological factors may very well contribute to both physical and psychological health concerns for the Hispanic elder population.

Many of the Hispanic elders living in this country emigrated from Mexico. Angel el al. (2008), studied various dimensions of physical and emotional health between older Mexican-origin individuals in the United States and in Mexico. The study included 3,875 Mexican residents with no history of residence in the U. S. and 2,734 Mexican-origin individuals age 65 and older who lived in the southwestern region of the U.S. The study found that both immigrant and native-born Mexican-origin elders in the U.S. report more chronic conditions than elderly Mexicans; however, they did report fewer symptoms of psychological distress. They also found that the longer the individuals had lived in the U.S., the higher their body mass index score. The researchers concluded that the there is a possibility that access to care influences reports of diagnosed conditions. Additionally, they also suggests that there may be comparability in cross-cultural research and the difficulty in distinguishing cultural and system-level factors in the production and measurement of health (Angel et al., 2008).

Masel et al., (2009) looked at frailty and health related quality of life in Mexican-American elders with specific interest in the relationship between being non-frail, pre-frail and health related quality of life in a representative sample of Mexican-Americans elders surveyed in 2005-2006. Conducting a multiple regression analyses from data from a representative subsample of the Hispanic Established Populations Epidemiologic Studies of the Elderly (EPESE) which included 1008 older adults living in the community, the authors examined the relationship between the frailty status and the survey's health related quality of life subscales and two summary scales (Masel et al., 2009). The researchers reported that the results of the study found that being pre-frail or frail was significantly associated ($p < 0.001$) with lower scores on all the physical and cognitive health related quality of life scales than being non-frail. Consequently, older Mexican-American individuals who identify as frail and pre-frail exhibit significantly lower health related quality of life scores (Masel et al., 2009).

The Masel study is significant because elder Hispanics tend to use formal home health care less than other elders. Kirby and Lau (2010) found that Hispanic elders are more likely to use informal home care if they live in communities with a higher proportion of residents who share their ethnicity. The authors conclude that there needs to be a better understanding of how informal care is provided in different communities to help inform policy makers who are concerned with promoting informal home care, supporting the informal caregiver, or providing formal home care as a substitute or supplement to informal care (Kirby and Lau, 2010). Additionally, this would significantly provide support to Hispanic/Latino families who receive the most informal

home care (44 percent when compared with blacks and non-Hispanic whites (Ferrini and Ferrini, 2008).

Kirby et al., (2010) also studied home health care use among elderly persons as it relates to community and individual race and ethnicity to see whether the interaction between individual race and ethnicity and community race and ethnicity composition was associated with health-related home care use among elderly persons. The researchers used a nationally representative sample of community-dwelling elders aged 65 and above from the 2000 through 2006 Medical Expenditure Panel Survey which was linked to block group-level racial and ethnic information from the 2000 Decennial Census. The total number surveyed was 23, 792 elders. The researchers estimated the likelihood of informal and formal home health care use for four racial and ethnic elderly groups; non-Hispanic whites, non-Hispanic blacks, non-Hispanic Asians, and Hispanics living in communities with different racial and ethnic compositions (Kirby et al., 2010). The principal findings revealed that non-Hispanic Asian and Hispanic elders living in block groups with $\geq$ 25 percent of residents being non-Hispanic Asian or Hispanic, respectively, were more likely to use informal home health care than their counterparts in other block groups. The authors concluded that both non-Hispanic Asian and Hispanic elders are more likely to use informal home care if they live in communities with higher proportion of residents who share their race and ethnicity. These findings again concur that a better understanding of how informal care is provided in different communities may inform policy makers to implement more effective measures in supporting informal home health care for elder populations.

Another significant psychological factor facing Mexican-American elders, who immigrate to the United States, is the problem of depression. Gerst et al., (2010) conducted a cross-sectional analysis again, using the EPESE to measure depressive symptoms among non-institutionalized Mexican-American men and women aged 75 and above. Logistic regression was used in a sample of 1,699 Mexican-American elders to predict high depressive symptoms and multinomial logistic regression was used to predict sub-threshold, moderate, and high depressive symptoms. The researchers found that elders born in Mexico had higher odds of more depressive symptoms compared to otherwise similar Mexican-Americans born in the U. S. (Gerst et al., 2010). Interestingly, the age of arrival to the U.S., gender, and other covariates such as health and cognitive status did not modify that risk, which suggests that older Mexican-American immigrants are at higher risk of depressive symptoms compared to persons born in the U.S. which could very well place significant implications for future research, policy, and clinical practice among this significant portion of the population (Gerst et al., 2010). The authors also asserted that their findings have policy, research, as well as clinical implications because older Mexican-Americans who may have higher rates of depressive symptoms compared to US-born persons may also suffer from lack of access to healthcare in which the use of formal mental health services may be utilized.

Kim et al., (2010) also looked at mental health service use in the Latino and Asian immigrant elder population. They sought to examine the factors associated with the mental health service use of Latino and Asian immigrant elders by adapting the Andersen's behavioral health model of health service utilization with the predisposing, enabling, and mental health need factors as predictors for use of mental health services.

The researchers used data from the National Latino and Asian American Survey (NLAAS) which is a nationally representative dataset. Using hierarchical logistic regression analyses of mental health service use for Latino (n=290) and Asian (n=211) immigrant elders, the study revealed that for both groups of immigrant elders who self-rated poor mental health was associated with significantly greater mental health service use. Specifically, for Latinos, use of mental health services was significantly associated with both predisposing factors of being younger and female and mental health need factors of having any mood disorder and poor self-rated mental health. Conversely with Asian elders, only mental health need factors such as having any mood disorders and poor self-rated mental health significantly affected mental health service use (Kim el al., 2010). Also, only with immigrant Latinos elders, poor self-rated mental health mediated the association between mood disorders and mental health service use. The researchers concluded that the results of their study highlight an important role of self-rated mental health as a potential barrier in the use of mental health services and consequently recommend that intervention strategies be used to enhance mental health service use in the Hispanic and Asian elder populations(Kim et al., 2010).

Review of Literature

Health behaviors in Hispanic elders differ in various areas which make them susceptible to become a vulnerable demographic. There are many reasons as to why certain demographics are more vulnerable to health care disparities. Factors such as financial barriers, physician and patient decision making, cultural and communication barriers, differences in disease severity and frankly racism are among the most common factors leading to disparities in health care (Ferrini and Ferrini, 2008). Additionally, low

health literacy or poor health literacy affects almost half of the adults in the U.S. and is more common among elders, particularly the very old and according to a Medicare study, more than one-half of Spanish-speaking patients had poor health literacy, with that number increased by eight times in the elders that are 85 years and older (Ferrini and Ferrini, 2008). This factor in itself has many consequences, such as poor compliance with instructions resulting in complications and subsequent high use for the health care system and an increase in the annual health care expenditure in the U.S. by $73 billion. Also, elders with poor health literacy have a higher incidence of poor control of diabetes with subsequent complications which often times leads to hospitalizations and more severely, diabetic complications such as retinopathy and blindness (NHCOA, 2007), which clearly impacts the elders' quality of life and severely decreases their independence.

Hispanic elders also face disparities in receiving crucial psychological interventions. Harris et al., (2010) looked at the challenges that Hispanic elders face when seeking screening and evaluation of memory impairment in a primary safety net clinic. Out of 677 eligible patients that were asked to participate, only 329 (49%) were screened, and 77 (23%) met the criteria for memory impairment. They found that only male gender with a higher comorbidity factor uniquely predicted memory impairment. The challenges to implementing a memory screening program included staff time and adequate clinic space for in-person screening. Additionally, follow-up with the positive screening results presented other challenges such as the inability to contact patients and lack of primary care continuity to facilitate further treatment and referral (Harris et al.,

2010). This study indicates a clear disparity in screening Hispanic elders who may benefit from early intervention for psychological impairments.

Borders (2004) sought to determine if there is Hispanic versus non-Hispanic white disparities in rural elders' reports of their health care access. In a telephone survey conducted among 2,097 rural community-dwelling elders in West Texas, Borders found that Hispanics had worse reports of their ability to always/usually see their personal doctor, see a specialist, obtain transportation to the clinic, see a doctor for illness/injury when wanted, and to see a doctor for routine care when wanted. This significant study highlights the need to enhance the health insurance coverage in order to improve access to personal doctors and specialists among all rural elders, especially Hispanics. The findings of the study clearly indicated that rural elderly Hispanics face greater problems gaining access to their personal doctor, specialist and transportation to the doctor's office than their non-Hispanic white counterparts (Borders, 2004). Borders (2004) indicated that using the Behavioral Model which has typically been used to study the determinants of health services use is well suited for investigating the effects of demographic, social, economic, and health status factors on reports of problems with access to care. The Behavioral Model can lead to insights about ways to improve access through the implementation or modification of social and economic policies. The original model theorized that 3 sets of factors, predisposing, enabling, and need influence whether individuals use medical care. Additionally, the predisposing factor, such as age, gender, ethnicity, and other immutable factors may place some individuals at differential risk of using health care services. Social support characteristics, such as marital status, and economic factors, such as health insurance coverage and income, may allow individuals

the means to use health care services more frequently are considered enabling factors. Need would be evaluated or perceived as health status and theorized as having the greatest influence on whether health care services were utilized. Because, as Borders (2004) points out, predisposing factors are largely immutable, public policies often focus on more modifiable factors such as income and insurance, and inequity in access is thought to occur if predisposing factors, such as ethnicity and race, or enabling factors are revealed to influence reports of health care access problems.

Acculturation is also another factor when assessing the health care utilization of elder Hispanics. Using the Andersen socio-behavioral model to better understand how acculturation impacts the health status by systematically assessing clusters of determinant factors and their impact on self-reported health (SRH), Johnson et al. (2010) found that Mexican-oriented acculturation remained an independent predictor of fair/poor health in the study's Hispanic participants. This finding supports the notion that self-rated health may be affected by a person's level of acculturation while controlling for certain predisposing, enabling, and need factors found in the behavioral model.

The Behavioral model has been used for quite some time to examine predisposing, enabling, and need factors associated with physician use by Hispanic elders as well as to assess whether Mexican American, Cuban American, and Puerto Rican elders differ in the reason for their use of physician utilization. The study found that all three sets of factors contributed to the likelihood of a physician visit (Burnette and Mui, 1999). Burnette and Mui (1999) found that enabling factors, especially insurance coverage and adult children, had the greatest impact on physician utilization by Hispanic elders. Furthermore, Mexican-Americans were less likely to seek medical attention than

Cuban and Puerto Rican Americans. It is clear that Hispanic elders, especially Mexican-American elders continue to experience decreased access to healthcare.

Interventions

At times health care providers may contribute to low health literacy without realizing it, especially, when they provide elders with too much information with medical jargon which the elders may have a hard time understanding (Ferrini and Ferrini, 2008). With the increasing numbers of elder immigrants who do not speak English, addressing the issue, by becoming culturally sensitive, and taking time to make sure patients are well informed before they leave the office. Additionally, health care providers can tailor discussions of health concerns and their treatments to the individual, which would be a crucial intervention (Ferrini and Ferrini, 2008).

Medical and public health professionals should promote the use of acculturation measures in order to better understand its role in Hispanic behaviors, health outcomes and health care use (Johnson et al., 2010). The NHCOA (2007) reports that the morbidity and mortality rates of the Hispanic elder population hinges on the mobilization of the healthcare system, healthcare providers, nonprofit organizations and the Hispanic community to address the host of challenges and barriers faced by Hispanic elders. As well as additional empirical evidence to examine the differentiations in health outcomes that are based on Hispanic origin, with specific research to determine ways in which certain illnesses can be prevented or treated more effectively within the elderly Hispanic population (NHCOA, 2007). Rios (2006) president of the National Hispanic Medical Association asserts that enhanced Hispanic health leadership such as increased representation of Hispanics as physicians is needed to eliminate health disparities among

the Hispanic population. Furthermore, Rios (2006) recommends that Hispanic students be encouraged to pursue health careers to increase cultural competence within the Hispanic population and ultimately Hispanic elders.

Community partnerships for evidence-based solutions to address health care disparities in Hispanic elders need to provide culturally and linguistically appropriate services throughout the country and not only in dense Hispanic communities. Culturally sensitive services that include medical care, counseling, nutrition programs, exercise classes and mental health services should be tailored to Hispanic elders. Health educators can also play a critical role in the provision of culturally competent health education to Hispanic elders. Health educators are at the forefront of healthcare delivery to provide expert and effective health promotion and disease prevention education to improve health in the community.

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